		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037424

Facility Name: FIRESIDE HOUSE OF CENTRALIA

Address: 1030 McCORD (Number) CENTRALIA (City) 62801 (Zip Code)

County: MARION

Telephone Number: 618-532-1833 **Fax #** 618-532-1308

IDPA ID Number: 431588535006

Date of Initial License for Current Owners: 12/05/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kathy Herman, HP/Mngt. Group Inc. **Telephone Number:** 770-619-0866 ext. 243

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from May 1, 2000 to April 30, 2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ October 31, 2001 (Date)
(Type or Print Name) Douglas K. Mittleider
(Title) President of HP/Management Group, Inc. - Management Co.

Paid Preparer

(Signed) _____ October 31,2001 (Date)
(Print Name and Title) Kathy Herman, Senior Reimbursement Analyst
(Firm Name & Address) HP/Manangement Group, Inc, 950 North Pointe Pwky, Suite 100 Alpharetta, GA 30005
(Telephone) 770-619-0866 Fax # 770-619-0262

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 05/01/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	24	Skilled (SNF)	24	8,760	1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,189	820	3,867	5,876	8
9	SNF/PED					9
10	ICF	16,320	3,485		19,805	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,509	4,305	3,867	25,681	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.79%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/05/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/16/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,750

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: April 30 Fiscal Year: April 30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 **Report Period Beginning:** May 1, 2000 **Ending:** April 30, 2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	106,029	8,847	9,556	124,432	(2,597)	121,835		121,835			1
2	Food Purchase		135,013		135,013	(1,113)	133,900	(114)	133,786			2
3	Housekeeping	77,431	8,343	731	86,505	560	87,065		87,065			3
4	Laundry	30,661	5,919	127	36,707	(63)	36,644		36,644			4
5	Heat and Other Utilities			84,225	84,225	(22)	84,203	(25)	84,178			5
6	Maintenance	20,467	3,001	15,119	38,587	(4,218)	34,369		34,369			6
7	Other (specify):* Waste Disposal					7,311	7,311		7,311			7
8	**TOTAL General Services**	234,588	161,123	109,758	505,469	(142)	505,327	(139)	505,188			8
	B. Health Care and Programs											
9	Medical Director			7,700	7,700		7,700		7,700			9
10	Nursing and Medical Records	797,752	35,512	7,941	841,205	(1,187)	840,018		840,018			10
10a	Therapy	4,691	43,636	192,984	241,311	(3,730)	237,581		237,581			10a
11	Activities	24,281	3,413	2,353	30,047	(2,353)	27,694		27,694			11
12	Social Services	16,888	23	1,304	18,215		18,215		18,215			12
13	Nurse Aide Training											13
14	Program Transportation			912	912	2,353	3,265	(3,265)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	843,612	82,584	213,194	1,139,390	(4,917)	1,134,473	(3,265)	1,131,208			16
	C. General Administration											
17	Administrative	61,220			61,220	4,733	65,953		65,953			17
18	Directors Fees											18
19	Professional Services			164,661	164,661	11,992	176,653		176,653			19
20	Dues, Fees, Subscriptions & Promotions			6,839	6,839	2,912	9,751	(1,624)	8,127			20
21	Clerical & General Office Expenses	69,351	12,421	37,185	118,957	(24,950)	94,007	(6,671)	87,336			21
22	Employee Benefits & Payroll Taxes			164,091	164,091	6,998	171,089		171,089			22
23	Inservice Training & Education			3,608	3,608		3,608		3,608			23
24	Travel and Seminar			6,820	6,820		6,820	(4,989)	1,831			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			45,954	45,954		45,954		45,954			26
27	Other (specify):*											27
28	**TOTAL General Administration**	130,571	12,421	429,158	572,150	1,685	573,835	(13,284)	560,551			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,208,771	256,128	752,110	2,217,009	(3,374)	2,213,635	(16,688)	2,196,947			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA #0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			137,612	137,612		137,612		137,612			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			272,761	272,761		272,761	(12,912)	259,849			32
33	Real Estate Taxes			14,948	14,948		14,948		14,948			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,992	3,992	917	4,909		4,909			35
36	Other (specify):*											36
37	**TOTAL Ownership**			429,313	429,313	917	430,230	(12,912)	417,318			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,363	7,399	114,762		114,762		114,762			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops					1,279	1,279	(1,279)				41
42	Provider Participation Fee			53,411	53,411		53,411		53,411			42
43	Other (specify):* **Lab Xray**			975	975	1,178	2,153		2,153			43
44	**TOTAL Special Cost Centers**		107,363	61,785	169,148	2,457	171,605	(1,279)	170,326			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,208,771	363,491	1,243,208	2,815,470		2,815,470	(30,879)	2,784,591			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(25)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(12,912)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(114)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,624)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,204)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,879)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (30,879)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops	X		1,279	41	40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,279		47

STATE OF ILLINOIS

FIRESIDE HOUSE OF CENTRALIA

ID# 0037424

Report Period Beginning: May 1, 2000

Ending: April 30, 2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	CONCESSION REVENUE OFFSET	$ (1,279)	41	1
2	RESIDENT TRANSPORTATION	(3,265)	14	2
3	BANK CHARGES	(6,671)	21	3
4	OUT OF STATE TRAVEL	(4,989)	24	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,204)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(114)	0	0	0	0	0	0	0	0	0	0	(114)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(25)	0	0	0	0	0	0	0	0	0	0	(25)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(139)	0	0	0	0	0	0	0	0	0	0	(139)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,265)	0	0	0	0	0	0	0	0	0	0	(3,265)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,265)	0	0	0	0	0	0	0	0	0	0	(3,265)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,624)	0	0	0	0	0	0	0	0	0	0	(1,624)	20
21	Clerical & General Office Expenses	(6,671)	0	0	0	0	0	0	0	0	0	0	(6,671)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,989)	0	0	0	0	0	0	0	0	0	0	(4,989)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,284)	0	0	0	0	0	0	0	0	0	0	(13,284)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,688)	0	0	0	0	0	0	0	0	0	0	(16,688)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 **Report Period Beginning:** May 1, 2000 **Ending:** April 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,912)	0	0	0	0	0	0	0	0	0	0	(12,912)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,912)	0	0	0	0	0	0	0	0	0	0	(12,912)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(1,279)	0	0	0	0	0	0	0	0	0	0	(1,279)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,279)	0	0	0	0	0	0	0	0	0	0	(1,279)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,879)	0	0	0	0	0	0	0	0	0	0	(30,879)	45

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED OWNER'S LISTING						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: ril 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Prudential Huntoon Paige		X	FIRST MORTAGE	$29,997.66	10-91	$ 2,957,900	$ 2,564,795	10/01/2032	9.1250	$ 237,050	1
2	Associates (HUD)											2
3												3
4												4
5												5
	Working Capital											
6	DVI Funding		X	Working Capital	N/A	04/30/99	297,821	135,209		Floating	30,149	6
7	HP Insurance		X	Liability/Propery Insurnace	N/A		Varies	Floating			5,562	7
8												8
9	TOTAL Facility Related				$29,997.66		$ 3,255,721	$ 2,700,004			$ 272,761	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,255,721	$ 2,700,004			$ 272,761	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 86,294	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 86,294	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 14,948	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 14,948	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	40,358	8
1997	43,139	9
1998	42,417	10
1999	43,877	11
2000	45,297	12

Accrued 4 months of the 2001 Liability

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FIRESIDE HOUSE OF CENTRALIA COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0037424

CONTACT PERSON REGARDING THIS REPORT Steve Henson - Tax Manager

TELEPHONE 770-619-0866 FAX #: 770-619-0262

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-100-006	Land & Buildings	$ 45,297.22	$ 45,297.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,297.22	$ 45,297.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,800 B. General Construction Type: Exterior BRICK Frame CONCRETE/STUCCO Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS	162,206	1991	$ 31,400	1
2					2
3	TOTALS	162,206		$ 31,400	3

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1991	1963	$ 2,033,543	$ 47,833	40	$ 47,833	$ 0	$ 472,105	4
5			1992	1992	846,649	19,914	40	19,914		178,596	5
6											6
7											7
8											8
	Improvement Type**										
9	CAPITAL INTEREST			1992	4,384	103	40	103		927	9
10	LIGHT FIXTURES			1993	74	5	15	5		39	10
11	TOILET STOOLS/LAVATORIES			1993	1,757	110	15	110		880	11
12	DOOR JAM GUARDS			1993	828	52	15	52		415	12
13	SURVEY			1993	1,000	25	38	25		195	13
14	McDANIEL MISC. PROJECTS			1993	2,000	125	15	125		991	14
15	FRONT AND REAR GUTTERS			1993	3,325	209	15	209		1,650	15
16	PLUMBING VALVE REPAIRS			1994	703	44	15	44		342	16
17	HUD LEGAL AND HUD SURVEY			1994	38,516	906	40	906		6,815	17
18	TILE REPAIRS			1994	458	11	40	11		80	18
19	CONSTRUCTION MATERIALS			1994	484	11	40	11		87	19
20	SURVEYOR & CONSTRUCTION DRAWINGS			1994	39,576	931	40	931		6,950	20
21	STORAGE TANK REPAIRS			1999	1,315	412	3	412		558	21
22	AIR CONDITIONING REPAIRS			1998	1,147	360	3	360		934	22
23	REPLACE WIRING AND MOLDINGS			1997	11,324	1,065	10	1,065		4,792	23
24	RE-ROUTE WATER LINES			1994	650	15	40	15		112	24
25	WET INSULATION AND DECK			1994	2,598	98	25	98		705	25
26	LAUNDRY LINT TRAP			1995	1,172	151	5	151		1,172	26
27	ELECTRIAL WORK			1997	7,256	683	10	683		2,896	27
28	LEASEHOLD IMPROVEMENTS 1999-2000			1999	5,591	1,315	4	1,315		2,566	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,004,350	$ 74,378		$ 74,378	$ 0	$ 683,807	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 672,235	$ 63,248	$ 63,248	$ 0	10	$ 458,407	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 672,235	$ 63,248	$ 63,248	$ 0		$ 458,407	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,707,985	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,626	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 137,626	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,142,214	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 4,909 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THIS FACILITY HIRES ONLY "CERTIFIED NURSING AIDES'

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	1,435	$ 74,929	$	1,435	$ 74,929	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		351	17,838		351	17,838	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,841	100,217	78	1,841	100,295	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				95,197		95,197	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & Xray	43-3				2,153			2,153	13
14	TOTAL			$	3,627	$ 195,137	$ 95,275	3,627	$ 290,412	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA **#** 0037424 **Report Period Beginning:** May 1, 2000 **Ending:** April 30, 2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** April 30, 2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (192,181)	$	1
2	Cash-Patient Deposits	1,627		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,777,374		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	78,752		5
6	Prepaid Insurance	25,211		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,690,783	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,400		13
14	Buildings, at Historical Cost	2,033,543		14
15	Leasehold Improvements, at Historical Cost	970,807		15
16	Equipment, at Historical Cost	672,235		16
17	Accumulated Depreciation (book methods)	(1,142,214)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,565,771	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,256,554	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,782,290	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,627		28
29	Short-Term Notes Payable	135,209		29
30	Accrued Salaries Payable	71,599		30
31	Accrued Taxes Payable (excluding real estate taxes)	49,784		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,948		32
33	Accrued Interest Payable	237,050		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Bed Tax	4,410		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,296,917	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(138,589)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (138,589)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,158,328	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 98,226	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,256,554	$	48

***(See instructions.)**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 200

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 184,083	1
2	Restatements (describe):		2
3	**Adjustment to Income PY**	(184,083)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	98,223	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding adjustment**	3	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 98,226	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 98,226	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,635,406	1
2	Discounts and Allowances for all Levels	178,356	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,813,762	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,715	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 85,715	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,279	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	25	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,304	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,912	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,912	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,913,693	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	505,469	31
32	Health Care	1,139,390	32
33	General Administration	572,150	33
	B. Capital Expense		
34	Ownership	429,313	34
	C. Ancillary Expense		
35	Special Cost Centers	115,737	35
36	Provider Participation Fee	53,411	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,815,470	40
41	**Income before Income Taxes (line 30 minus line 40)****	98,223	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 98,223	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,142	2,419	$ 52,225	$ 21.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,145	14,846	225,820	15.21	3
4	Licensed Practical Nurses	9,067	9,287	108,722	11.71	4
5	Nurse Aides & Orderlies	50,001	51,279	374,683	7.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,292	3,491	24,281	6.96	10
11	Social Service Workers	1,858	1,939	16,888	8.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,408	15,966	106,029	6.64	15
16	Dishwashers					16
17	Maintenance Workers	1,911	2,148	20,467	9.53	17
18	Housekeepers	11,676	12,574	77,431	6.16	18
19	Laundry	5,159	5,329	30,661	5.75	19
20	Administrator	2,080	2,080	61,220	29.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,833	5,377	69,351	12.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,773	4,232	40,993	9.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,345	130,967	$ 1,208,771 *	$ 9.23	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	186	$ 6,960	1-3	35
36	Medical Director		7,700	9-3	36
37	Medical Records Consultant	49	1,838	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,569	39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	1,793	11-3	44
45	Social Service Consultant	33	1,304	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	307	$ 22,164		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathy Berck	Administrator		$ 41,177
Dave Eifert	Administrator		24,776
Wages reclassed from Clerical			(10,510)
Vacation reclassed from Clerical			(1,220)
Benefits reclassed			6,997
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,220

B. Administrative - Other

Description	Amount
NOT APPLICABLE	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HP/MANAGEMENT SERVICES	FACILITY MNGT.	$ 164,661
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 164,661

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,622
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	7,874
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentives	916
All Payroll Taxes	116,677
TOTAL (agree to Schedule V, line 22, col.8)	$ 171,089

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NOT APPLICABLE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,577
Health Care Worker Background Check	195
(Indicate # of checks performed 6)	
Chamber of Commerce Dues	812
Promotional Advertising	812
Costcor Administrative Fees	1,968
Publications	346
Permits	44
Illinois Health Care Dues	3,797
Less: Public Relations Expense	(812)
Non-allowable advertising	(812)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel - Lodging	4,790
Meals	199
In-State Travel	
Mileage	519
Meals	267
Travel - Tolls , parking etc	200
Seminar Expense	845
Entertainment Expense	(4,989)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,831

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: May 1, 2000 Ending: April 30, 20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC. 3,797**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NA**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,222** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,411**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **NA** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **NA**
c. What percent of all travel expense relates to transportation of nurses and patients? **NA**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **NO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.